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ABSTRACT

This journal issue concerns research projects conducted at the Hispanic Research Center of Fordham University in New York City. In the first article, Luis R. Marcos discusses research on the psychiatric evaluation and psychotherapy of bilingual Hispanic patients, focusing primarily on linguistic factors which affect evaluation and treatment of the Hispanic population. A number of specific diagnostic and treatment strategies are evaluated and recommendations for mental health professionals who deal with bilingual patients are offered. In the second article, "Alternative Models of Service Delivery for the Hispanic Elderly," Marta Sotomayor claims that existing services have not kept pace with the needs of the Hispanic elderly and suggests the use of social and familial networks to close the gap. In the final article, "Undocumented Migration: Issues and Trends," Elizabeth Collado discusses a lecture presented by Dr. Charles Keely, including an overview of U.S. immigration policies and their effect on undocumented immigration. The article contends that immigrants themselves have been the victims of economic hard times in the United States, and that their negative impact on the economy has been exaggerated. Increasing immigration quotas and dropping the country of origin specification are recommended as policy reforms. (AOS)

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The Psychiatric Evaluation and Psychotherapy of the Hispanic Bilingual Patient

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"The Psychiatric Evaluation and Psychotherapy of the Hispanic Bilingual Patient," by Luis R. Marcos

"Alternative Models of Service Delivery for the Hispanic Elderly," by Marta Sotomayor

"Undocumented Migration: Issues and Trends," by Elizabeth Collado

RESEARCH BULLETIN

Hispanic Research Center

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RESEARCH REPORT

FROM ITS VERY INCEPTION the Hispanic Research Center has been interested in the important area of psychiatric evaluation and psychotherapy among Hispanic patients. There is some evidence that cultural and linguistic differences between therapist and client introduce distortions into the evaluation process and lead to incorrect diagnoses and misapplication of therapeutic procedures. At the same time, the Hispanic Research Center has been committed to the study of support networks which mitigate the pressure of external stresses in the lives of Hispanics, particularly among the aged. Therefore, we take special pleasure in presenting our readers with two papers which discuss these extremely important issues. The first, "The Psychiatric Evaluation and Psychotherapy of the Hispanic Bilingual Patient," represents a pioneering research effort carried out by Dr. Luis Marcos and collleagues. The second, "Alternative Models of Service Delivery for the Hispanic Elderly," by Dr. Marta Sotomayor, discusses a theme of arresting interest in the lives of the Hispanic elderly and for those dedicated to providing them with efficient and culturally relevant services in the field of mental health. We are certain our readers will profit from sharing the experiences and ideas expressed in both papers.

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THE PSYCHIATRIC EVALUATION AND PSYCHOTHERAPY OF THE HISPANIC BILINGUAL PATIENT

By Luis R. Marcos, M.D., Director, Department of Psychiatry, Gouverneur Hospital, and Associate Professor of Psychiatry, New York University of Medicine

☐ The research projects described in this Report were carried out by Dr. Marcos as principal investigator. Co-authors in these projects were Murray Alpert, Ph.D., Martin Kesselman, M.D., Manuel Trujillo, M.D., and Leonel Urcuyo, M.D. Parts of this material have been published by the American Journal of Psychoanalysis, American Journal of Psychiatry, American Journal of Psychotherapy, and Archives of General Psychiatry.

I. Introduction

AT GOUVERNEUR HOSPITAL, as in many other urban psychiatric centers, Hispanic bilingual patients constitute the largest proportion of the patient population (70%). During the past eight years we have studied the effects of the language of interview on the psychiatric assessment of bilingual Hispanic patients. A consistent finding has been that the clinician's frame of reference applicable to the Anglo-American patient is not appropriate for the evaluation of bilingual patients who are affected by cross-language and cross-cultural factors. The purpose of this Report is to present our research and major conclusions.

Bilingualism and bilinguals have been the subject of many studies by linguists, educators, sociologists and experimental psychologists. The interest of mental health clinicians in the subject, however, has been limited and only recent. While the existing literature offers a wide diversity of views on bilingualism, most authors agree that the bilingual experience has major effects on the individual's development and personality formation. The writings of the thirties and forties stressed the detrimental effects of bilingualism. For instance, several authors have considered bilingualism as predisposing towards schizophrenia, mental retardation and even character degeneration. These pessimistic judgements seem to share the rationale that two languages produce two personalities which necessarily result in psychological conflict. More recently, when bilingualism was analyzed independently of other stressful sociological variables such as migration, acculturation, biculturalism and social marginality, the conclusions have been different. In fact, there is some evidence which indicates that having two languages may help some individuals to become more flexible in their thinking and more diversified in mental abilities such as concept formation.

With respect to the psychiatric evaluation and treatment of the Hispanic population, a number of authors have pointed out the need for mental health professionals who possess both fluency in Spanish and a sensitive understanding of the Hispanic culture.

Although it is difficult to conceive a language without considering the culture in which it is used, forced by the limitations imposed by the experimental model, we

decided that our line of research would focus primarily on the linguistic factors affecting the evaluation and treatment of the Hispanic population. This choice by no means implies a belief that cultural factors do not play a significant role in the evaluation and treatment of Hispanic patients, but rather that the sheer ability to speak a language is less elusive to measurement than the sensitivity to a culture. We also thought that considering the emphasis on communication dysfunction in major theories of psychopathology, it was surprising that the role of language in the assessment and treatment of bilingual patients had received such little experimental attention.

II. Dimensionality of Bilingualism

As an introductory step, let us broadly define bilingualism as the practice of speaking two languages, and bilinguals as the individuals involved. The bilingual individual and his relation to the two languages can be studied from different perspectives. These include a variety of dimensions of bilinguality which deserve careful consideration if we are to understand the bilingual.

1. The first dimension is related to the language dominance of the bilingual; that is, the degree of proficiency or competence the bilingual has in each language. According to this dimension, bilinguals may be classified as subordinate or incipient, when their linguistic performance shows a differential competence in the two languages, or as proficient for some "true" bilinguals who have a native speaker's command of both languages. The fundamental characteristic of subordinate bilinguals is the language barrier or degree of linguistic difficulty involved in the processing of information in the less dominant language. Evidently, speaking in the nondominant language requires a more elaborate cognitive work than communicating in the dominant language. Not only the number of words available, but the capacity for grammatical ordering and the facility in articulating the words are inferior in the nondominant language, but also imposed upon the subordinate bilingual by the language barrier is the additional mental operation of constant translation from or into his dominant tongue.

2. A second dimension of bilingualism is the level of language independence; that is, the bilingual's capacity to acquire and maintain two separate language codes, each with its own lexical, syntactic, phonetic, and ideational components, and to use them independently with minimal interaction. These bilinguals, who are usually proficient in the two languages, operate parallel verbalization mechanisms, each with its own stream of associations between the words and the events in their ideational system. For example, for a Spanish-English bilingual, the word "perro" will be linked to a certain stream of associations, connotative meanings, and idiosyncratic emotional experiences. For the same individual, the translation equivalent "dog" may well be identical in central denotative meaning, however, the associations, metaphorical extensions and affective accompaniment may differ significantly.

This important dimension of language independence rests primarily on three factors and their interaction:

a) Whether the bilingual has learned both languages in the same or different contexts. In general, acquisition contexts are considered different when one language is learned in a cultural setting distinct from that in which the second language was acquired and/or when one language was learned at a later post-infancy period.

b) The current language-use context of the bilingual; that is, whether the bilingual individual utilizes exclusively one language in a specific domain or not. These domains of behavior may involve the person's work setting, family life, certain relationships or intellectual matters.

c) The languages' semantic compatibility; that is, the degree of semantic consistency and congruency between the two languages of the bilingual individual. An example of language incompatibility is the lack of translation equivalents for everyday terms in one of the languages spoken by the bilingual. For instance, in Spanish there are two possible translation equivalents, "tu" (intimate) and "usted" (formal), corresponding to the English second-person singular pronoun "you." In Spanish there are important psychological implications which devolve around whether to select one term or the other.

Bilingual individuals who have learned each language in different acquisition contexts, who use each language in specific domains, and whose two languages' semantic features differ from each other, are characterized by being higher in this language independence dimension.

3. The third major dimension of bilingualism refers to the individual's attitude and emotional attachment to each of the languages. For instance, a bilingual individual may consider one of his languages as an asset to his personality and general identity or, on the contrary, as deleterious. This dimension of language attitude is usually related to the particular wishes and the cultural and social values which the person links to the language.

Naturally, these three major bilingual dimensions of language dominance, language independence, and language attitude are not mutually exclusive and in their different levels overlap with each other. In the following section I will describe the most important clinical and experimental research that we have carried out in the past seven years, research which addressed the linguistic configurations of bilinguals along the above dimensions.

III. Research Projects

1. Evaluation of Psychopathology across the Language Barrier

The effect of the language barrier on the assessment of pathology in Hispanic subordinate bilingual patients was the topic of our first research project at Bellevue Psychiatric Hospital.

Previously we had developed a method for obtaining standardized psychiatric mental status evaluations utilizing a combination of prerecorded interview questions and videotape. This procedure provided a reliable method for minimizing interview variability. It was our expectation that by separating the clinicians from the interview situation we would be able to derive a clearer understanding of the language barrier effect.

For this study, ten recent admissions to the adult services of Bellevue Psychiatric Hospital were selected. The patients who volunteered for the study had been diagnosed as suffering from schizophrenia independently by two psychiatrists, had no evidence of an organic brain disorder, had Spanish as their native dominant language but had enough fluency in English to participate in English psychiatric interviews. Four psychiatrists contributed independent ratings of these patients' psychopathology by watching the videotapes of the interviews. Two psychiatrists were fluent bilinguals but had Spanish as their mother tongue and two were English speaking. The four psychiatrists had previously participated in training sessions designed to establish acceptable levels of reliability and were blind as to the purpose of the study. The material to be rated consisted of videotape recordings of standard psychiatric interviews in English and Spanish. Half of the patients participated in the English interview first and vice versa. The two interviews were spaced no more than 24 hours apart, and during this period no change was made in the patient's medication. The English and Spanish questions, which were identical, had been recorded on audiotape and were presented in the same order. The videotape recordings of the English-language interviews were independently rated by the two English-speaking psychiatrists and the

interviews in Spanish were also rated independently by the two Spanish-speaking psychiatrists. All the clinicians used the standard Brief Psychiatric Rating Scale for the assessment.

The results indicated that significantly more psychopathology was detected during the English interview for each patient. Subsequently, we analyzed each of the patients' symptoms individually. The statistical analysis demonstrated that out of the 18 symptoms studied, seven were found to be significantly higher in the English interview than in the Spanish interview. They were: physical tension, unusual movements, depressed mood, hostility, anxiety, emotional withdrawal, and somatic concerns.

To explain these results we considered three general factors: one related to the clinicians, one related to the patients, and one residing in the interaction between clinicians and patients. First, we hypothesized that since the patients were actually the same in the English and the Spanish interview, the higher pathology scores given by the English-speaking clinicians and the lower scores given by the Spanish-speaking clinicians reflected clinicians' bias. At that time we could not exclude the possibility that both positive and negative clinician prejudice could have contributed to the different levels of pathology found.

The second factor that might have operated, we thought, was related to the notion that the patients actually changed for the worse when they were required to speak in English. The third factor had to do with the possibility that the clinicians' frame of reference may not have been applicable to the special problems of our Hispanic patients. In addition, cross-cultural factors might have played an important role. For example, it is a well-known fact that Hispanic patients tend to express psychological difficulties through somatic complaints. Thus one might expect an elevation on the rating of the symptom somatic concern by the English-speaking clinicians. However, Spanish-speaking clinicians, with a more cultural familiarity, were better able to evaluate these patients' physical complaints within the context of their Hispanic cultural background.

2. Verbal and Nonverbal Communications across the Language Barrier

Since we were concerned with uncovering the manner and extent to which the language of the interview produced changes in the patient's communications, we undertook as our next study the analysis of the content of all the psychiatric interviews which had been videotaped. Thus, to determine the differences between the English and Spanish interviews for each patient, two bilingual psychiatrists compared the verbal content and vocalizations of the English and Spanish interviews for each patient. The two bilingual clinicians analyzed the tape and verbatim transcripts of the interviews. Each pair of interviews was judged for differences and similarities in content and infracontent, or paralinguistic aspects of communication such as speech rate, silences and speech disturbances.

Clear and consistent differences were found between the English and Spanish interviews. The content changes were classified according to three groups:

a) Changes in the sense of the response. On numerous occasions the patients gave different responses to the same questions in English and Spanish. Most often, the response in English suggested greater psychopathology.

b) Length of responses. There was a striking tendency in the Hispanic patients to answer the English questions with a short sentence, a word, or even a silence. A significant proportion of the questions were answered either with "I don't know," "I don't think so," or "No sir."

c) Translation difficulties. In addition to the obvious and expected difficulties in understanding questions and finding words to satisfy their communicative intent, the patients frequently showed a surprising amount of difficulty in using the past tense when interviewed in English. Another related issue was "language mixing." Thus, a majority of the patients utilized Spanish words during their English interviews, some of them quite frequently. This language intrusion made their flow of thought sound less logical and more confused.

The infracontent components of the speech studied included speech disturbances, speech rate, and silent pauses. Examples of speech disturbances were the sound "ah," sentence correction, sentence incompletion, repetition, stutter, and incoherent sounds. These have been suggested to be indicators of anxiety for English-speaking patients.

Our analysis demonstrated that during their English interviews the patients produced significantly more speech disturbances, particularly incoherent sounds. As expected, during the Spanish interviews the patients showed a higher speech rate, suggesting a greater fluency in that language. Finally, during the English-language interview the patients showed longer silent pauses. It appeared that speaking in English may have had a low activation effect on speech similar to what has been described in depression.

The main conclusion of this study was that during the English-language interviews patients did, in fact, act differently in ways which the English-speaking clinician was likely to associate with increased psychopathology.

When Hispanic patients attempt to speak a language other than their dominant tongue they create problems both for themselves and for the clinician. Communicating their thoughts in a relatively unfamiliar language imposes an additional burden on the patient's already failing efforts to organize a confusing subjective experience. Under these circumstances, the disturbances in fluency, organization, and integration occur in English while they are absent in Spanish. It became evident that the psychiatrists' frame of reference, which is applicable to native English-speaking patients, could not be directly applied to the evaluation of patients' behaviors which are influenced by psychopathology as well as by cross-language factors.

Since Hispanic patients had been evaluated as significantly more tense and more inappropriate in their movements during their English interviews, we proceeded to compare the hand movement activity of each patient in the English and Spanish interviews. The comparative study of their hand movements suggested that the real increase in motor behavior observed by the clinicians during the English-language interviews was due to an overproduction of movements which is known to be associated with the more demanding encoding task in the nondominant language and not to psychopathology. In fact, the rate of non-representational hand movements, characterized by lacking verbal referents, was found to correlate significantly with the clinical ratings of tension and abnormal movements during the English-language interview.

A subsequent replication study utilizing normal bilingual Spanish-English subjects confirmed the previous finding that individuals verbalizing in a nondominant language produce more hand movements than during their verbalizations in their dominant language. The specific hand movements that are produced during nondominant language speech consist of activity with no message content value but with the function in the process of verbalization, that is, movements that facilitate the process of transforming ideas into words. Therefore, clinicians evaluating subordinate bilingual patients with a significant deficit in the language of interview should be careful to distinguish those movements that reflect verbalization work from motor behavior which expresses psychopathology.

3. Bilinguals' Language Independence

To study the dimension of language

independence, we carried out a project to examine the evidence for this intriguing phenomenon as well as its possible ways of operating in the psychiatric evaluation and treatment of Hispanic bilingual patients.

First, compelling evidence for language independence stems from neurological studies of aphasia in bilinguals. Following cerebral vascular accidents or during deteriorating organic brain syndromes, bilingual individuals often exhibit differential impairment in their two languages. A similar effect has been reported in bilingual psychiatric patients after electric convulsive therapy.

In the psycholinguistic field, investigators have also demonstrated empirically that bilingual subjects verbalize different associations in response to semantically identical words, according to the language in which the task is performed. In general, these studies suggest that words referring to concrete objects elicit more similar responses in the bilingual's two languages than do abstract words which, in turn, tend to evoke more similar associations than words referring to feelings. Thus for a Hispanic proficient bilingual the words "mesa" and "table" may generate approximately the same mental representations; "libertad" and "freedom" will arouse different ones, and the words "amor" and "love" will mean and feel quite different.

The use of projective tests in bilinguals has shown that perception of role, recall, and projection of past experiences are significantly affected by the language of report. Also, some personality structures and characterological traits have been found to change according to the language of the bilingual. These findings take us to the still controversial language relativity hypothesis. This assumption postulates that language is not merely a vehicle of communication by which people talk about things, but rather that language itself represents a reality by means of which people perceive, structure and organize their world. Accordingly, bilingual individuals would be led by different pictures of the universe, depending on which language they speak.

In a recent clinical project we considered the effect of the language independence upon the sense of self of some patients. Specifically, we focused on the clinical observation that bilingual patients often report the experience of a language-specific sense of self; that is, they feel and perceive themselves as two different persons according to the language that they speak. In our work with Hispanic bilingual patients who report this experience of a language-specific sense of self, we have found that they frequently describe disturbances in their awareness of self; for instance, they feel that they act automatically or compulsively only in one of the languages. Some patients also report a loss of emotionality or lack of feelings when verbalizing in one language and they often complain that they "hear" themselves as two distinct individuals according to the language that they speak. Some of these patients also report "not being the same person" they used to be prior to their learning the English language.

In another clinical observation, the case history of a Hispanic bilingual woman was described. During psychotherapy, the patient always chose to speak English, her second language. For more than one year, I later found, this bilingual patient withheld information and lied about important aspects of her personality. It was only when she was urged to use the Spanish language, her mother tongue, that her lying became apparent. It appeared that this patient's superego control was stricter in her mother tongue and made it impossible for her to maintain deception in that language.

Some Hispanic patients may unconsciously utilize the language-specific self to deny unacceptable trends and impulses. Usually these dynamics are found in patients who attempt to deny their original identity linked to the Spanish language by emphasizing a "new" identity supported by the English language. At any rate, this language-related sense of dual self of bilinguals, with its conscious and unconscious ramifications, often constitutes a source of conflict, identity confusion, and becomes the trigger mechanism of complex intrapsychic turmoil. The degree of alienation, splitting, and dissociation which results, however, varies from patient to patient and so do the implications for the treatment.

IV. Clinical Implications of Bilingualism

1. The Mental Status Assessment

The patient's mental status is systematically assessed by the clinician in the interview setting. Information on areas of the patient's behavior relevant to psychopathological states is gathered by direct observation of the patient. In assessing the patient's mental status, the clinician must consider alternative diagnoses and recommend a treatment plan.

In our clinical studies which included a large number of psychiatric evaluations of Hispanic bilinguals, we were able to identify and systematize major effects of bilingualism on the different components of the patient's mental status.

A. Patient Attitude toward the Clinician

We have observed that Hispanic bilingual patients with a language barrier tend to behave in a passive way during English psychiatric interviews. This compliant attitude is often interpreted by the interviewer as an indication of uncooperativeness and guarded behavior. Apart from the patient's culturally "preset" unfavorable expectations of the Anglo clinician, there are a number of nondominant-language behaviors which can create the impression of the patient's slow and reluctant participation in the interview process. For instance, as we reported in our previous research with Hispanic bilingual schizophrenic patients, many patients tend to answer the English questions with short sentences, a word, or even a silent pause. This is easily interpreted by clinicians as defensive reluctance to communicate.

In addition, the patient's attitude toward the particular language of the interview may easily permeate his attitude about the clinician. In general, Hispanic patients with Spanish as their dominant language show a preference to be interviewed in Spanish. In the course of our work, however, we have studied situations in which a primarily Spanish-speaking patient has refused to speak in Spanish while expressing his preference to communicate in English. This reaction is probably related to the additive-substractive dimension of bilingualism, and the values and attributes associated with each language by the patient.

B. Motor Behavior

In clinical psychiatry, the evaluation of the patient's movements has always been considered a fundamental part of the mental status examination. As we indicated before, Hispanic bilingual patients when interviewed in English tend to be evaluated by clinicians as exhibiting more motor tension and more unusual movements. On the other hand, subsequent studies have shown that when bilinguals communicate in their nondominant language they use more hand movement activity. In fact, this extra hand activity has been considered to have a facilitatory function in the process of transforming ideas into words. In the light of these findings, clinicians assessing the motor behavior of Hispanic subordinate bilingual patients may be interpreting some of these verbalization-related movements as reflecting tension, anxiety or mannerisms, thus ascribing to psychopathology what belongs to the adaptive task of compensating for a verbalization handicap.

C. Speech

The evaluation of the patient's speech and stream of thought constitutes a fundamental component of the mental

status. This includes the tone and rate of speech, grammatical and semantic congruency, and the relation among the ideas which are being verbalized. As described before, our content analysis of interviews of Hispanic subordinate bilingual patients shows that the patients tend to produce more speech disturbances and longer silent pauses, and to mix Spanish and English words. Therefore, English-speaking clinicians may interpret these language-related effects as indicators of disturbances in thinking, whereas they really derive from the special problems posed for patients when they are interviewed across the language barrier.

D. Thought Content

In the content analysis of psychiatric interviews of Hispanic patients we find that on numerous occasions the patients give different responses to the same question in English and Spanish. Most often the English responses suggest greater psychopathology. A critical issue in the interpretation of this finding is whether the greater pathology in the English language is real or one based on interview conditions. One might wonder which interview reflects the "true" condition of the patient. It seems reasonable, however, to assume that the linguistic demands contribute to the manifest level of psychopathology and that under the lower pressure of the Spanish-language interview, patients are in fact less ill.

Beyond the linguistic problems, the assessment of the thoughts of the patient involves understanding the culturally bound attitudes which permeate the patient's thought content, emotional experience and behavior. In this regard, Hispanic patients are characterized by specific cultural values which are often misunderstood or misdiagnosed by clinicians who are unfamiliar with the Hispanic culture. Some of these attitudes include the concepts of spiritualism, santeria, respeto, dignidad, ataque, black magic, visiones, and other cultural beliefs such as disposition toward authority, and the notion of time, to mention only a few. Obviously, a valid evaluation of thought content in Hispanic patients requires both familiarity with the effect of bilingualism and knowledge of the Hispanic culture.

E. Emotions

The clinician's task in evaluating the patient's emotions is to assess the feelings that accompany the ideas verbalized by the patients. In addition, facial expressions and other nonverbal behavior may convey to the clinician the patient's emotional state.

In general, Hispanic bilinguals are found by clinicians to be more anxious, more depressed and emotionally withdrawn when the interview is conducted in English than when it is in Spanish.

Our clinical experience and experimental findings indicate that it is possible that the extra cognitive demands placed on bilinguals when speaking across the language barrier often determine a deflection of affect and attention into the task of verbalizing itself. Thus, the patients tend to invest their emotions in how they say things and not in what they are saying. This is manifested by verbalizing emotionally charged material without displaying the expected emotion. In addition, subordinate bilinguals, speaking in their nondominant language tend to utilize translation equivalents. These translation equivalents have been found to be less meaningful and emotional, and produce less vivid associations.

It is a well known fact, for instance, that subordinate bilinguals' reaction to saying taboo words is more intense when they verbalize the words in their dominant language. Also, it appears that the degree of affect and emotional reaction linked to words does not reside so much in the knowledge of what the particular word means, but rather is related to the age at which the word was learned. Thus, when a patient's significant experiences are verbalized in the language in which they did not take place, the patient may not show the appropriate emotional involvement.

2. The Process of Psychotherapy

A. Emotional Involvement

As we have seen, Hispanic bilingual patients when speaking in their nondominant language, usually English, tend to displace their emotions and feelings toward the more elaborate verbalization task. In psychotherapy, this diminution in the affective tone may be responsible for experiences to be felt as vague and unreal by both the patient and the psychotherapist. In their nondominant language, these patients may also have difficulty in experiencing and benefitting from therapeutic processes such as catharsis and abreaction.

We have also found that some patients may capitalize on the cognitive demands of the nondominant language and show constant concern about wording, grammatical constructions and pronunciation. This often results in the use of cliches and other forms of emotional avoidance, intellectualization and reaction formation.

Hispanic subordinate bilinguals often complain that they are unable to understand and derive full meaning from the therapist's vocal cues such as intonation, pauses and emotional tone. In fact, under experimental conditions, it has been shown that subordinate bilinguals are more likely to rely on content when listening to statements in their nondominant language, whereas they rely more on intonation and other vocal cues when listening to statements in their dominant language.

When subordinate bilinguals speak in their nondominant language they perceive their interviewer as relatively unfavorable and feel themselves to be less intelligent and self-confident than they might otherwise feel. These findings suggest that apart from its effects on communication, the language barrier in a dyadic setting such as psychotherapy, may have negative implications for both the image that the patient has of himself and his image of the psychotherapist.

The language barrier's interference with the patient's emotional release may set in motion feelings of frustration in the patient and mechanisms of regression. On the other hand, the demands placed upon the therapist to decide which of the patient's verbal cues are relevant and which are a mere consequence of the patient's linguistic deficit may give rise to feelings of frustration in the therapist and rejection of the patient.

B. Resistance, Facilitation, and Language Switching

However, bilingual patients may be able to reveal in their nondominant language experiences which in the dominant language would have remained unsaid due to their high emotional component. In this sense, in order to bring about therapeutic verbalization of anxiety-provoking memories, the patients may be asked to approach painful material through their nondominant language which tends to have less emotional component as well as a more permissive superego. In this way, the patient's use of the nondominant language may facilitate the psychotherapeutic process.

The implications for psychotherapy of a high degree of language independence include the unavailability of areas of the bilingual's intrapsychic world which remain unverbalized due to the fact that they are independent of the language system in which the treatment is conducted. It is a common finding among clinicians that childhood memories come alive in psychotherapy only when the verbal expressions of that period are used.

When the patient and the psychotherapist are bilinguals themselves and the treatment is open to the use of either language, language switching may have either inhibitory or facilitating effects,

but it very often offers the bilingual opportunities for resistance. Thus the patient may choose to speak in the more abstract, detached language to avoid anxiety.

In a recent report we presented the therapeutic use of language switching in the psychotherapy of a bilingual patient. The patient, a young Hispanic bilingual, was suffering from depression with phobic symptoms. In the first two months, the sessions were conducted in Spanish, the patient's first language. This allowed the patient to freely explore her most immediate problems and to develop a trusting relationship with the psychotherapist. Following this preliminary period, it was decided that the therapist would begin to switch to English at points of increased emotional arousal. This maneuver facilitated the patient's effort to objectify emotionally charged issues. It may be concluded in this regard that the dominant language has a higher emotional structure which can capture greater richness of experience but, by the same token, inhibits the patient's ability to gain distance and profit from more intellectual coping mechanisms.

V. Recommendations for Mental Health Professionals

Clinicians evaluating or treating Hispanic bilingual patients should be sensitized to the significance of the individual's linguistic dimension and its effect on the processes of communication, psychopathology, and psychotherapy. A clinician who is unfamiliar with the implication of bilingualism may easily misevaluate the patient's attitude, and his verbal and nonverbal reponses by neglecting their possible linkages to the person's linguistic configuration.

The different dimensions of bilingualism, primarily the language dominance, the language independence and the language attitude, have such practical importance for the psychiatric evaluation and psychotherapy of Hispanic bilinguals that the prognosis for successful outcome may depend upon the language of the interview, treatment and the strategic handling of the two-language system.

Understanding the Hispanic bilingual communicative behavior requires that clinicians carefully estimate the degree of language dominance, the potential for non-congruence of the patient's languages, and the patient's attachment and attitudes to the two languages. Aspects that should be routinely explored include the patient's language competence, developmental stages, cultural context, and interpersonal relationships associated with both languages; values, feelings and sense of identity linked to each language; and possible semantic incompatibilities between the two languages.

It would be optimal to have enough Hispanic mental health professionals so that Hispanic patients could receive the same level of care as the rest of the population. Short of this, it is imperative that clinicians be familiarized with the special communicative problems associated with bilingualism, the bilingual experience, and the culturally bound attitudes of the Hispanic population.

The Use of Interpreters in Psychiatry

Although a number of Hispanic patients speak enough English to allow some communication in this language, frequently the patient's competence in the English language is so low that the only way to establish communication is with the help of an interpreter.

Since psychiatric hospitals have no official interpreters, when a non-English-speaking patient has to be evaluated, any available individual who can speak Spanish may be asked to participate as an interpreter. This person may be another patient, a patient's friend or relative, or any member of the hospital staff.

Recently, a research project was carried out with the purpose of exploring the distortions produced by this common practice, and of making specific recommendations so that English-speaking clinicians examining Hispanic patients through an interpreter would be able to minimize the constant errors resulting from this interview situation.

For the procedure, psychiatric evaluations of non-English-speaking patients conducted through an interpreter were recorded on audiotape for content analysis. The patients had volunteered for the study. An English-speaking psychiatrist conducted the interviews with the help of an interpreter.

To analyze the content of the recorded material, bilingual clinicians listened to the audiotapes and compared the English portion with the Spanish portion of the interview as to their clinical equivalence. Specifically, these clinicians compared the content of the interviewing psychiatrist's questions with the interpreter's translation of the questions to the patient, and the content of the patient's answers with the interpreter's translation of such answers to the interviewing psychiatrist.

The content analysis of the recorded interpreter-interview evaluations revealed a variety of distortions. The findings are organized according to three major types:

A. Interpreter's language competence and translation skills.

Although in general the interpreters participating in the recorded interviews were proficient bilinguals, various types of clinically relevant errors of translation were detected. These included omissions, additions, substitutions, and condensations. Such distortions appear to be related both to the interpreters' insufficient level of language dominance and to their deficient interpretative skills.

From the recorded interviews a number of distortions were also detected when the interpreters attempted to translate patients' long answers. Usually, summaries of these answers resulted in an important loss of information.

B. Interpreter's lack of psychiatric knowledge.

The most frequent distortion in this category consisted of the "normalization" by the interpreter of patients' thought disorders such as circumstantiality, tangential thinking, loose associations, and blockings. Listening to the tapes it became obvious that interpreters would often try to "make sense" of the patients' disorganized statements, preventing the clinician from detecting these important aspects of the mental status.

Also the quality and depth of the patient's affect could not be reliably assessed through the interpreter. This may be related to the fact that interpreters tend to limit their translation to <u>what</u> the patient says, and neglect <u>how</u> the patient says it.

C. Interpreter's role in the interview process.

In those interviews where the interpreters were relatives of the patient, a tendency on their part to either minimize or emphasize psychopathology was often detected. Another common observation detected in the interviews where the patient's relatives were utilized as interpreters consisted of the interpreter answering the clinician's questions to the patient without actually asking the patient. This usually occurred when anxiety-provoking questions such as suicidal thoughts were asked.

The above findings suggest that clinicians evaluating non-English-speaking patients through an interpreter are confronted with consistent, clinically relevant, interpreter-related distortions which may give rise to important misconceptions about the patient's mental status. Apart from the distortions associated with the relative untranslatability of communicative components such as the formal aspects of the speech, expression of affect, and the paralinguistic aspects of the patient's verbalizations, three major sources of interpretative distortions were identified: distortions associated with defective linguistic and/or translation skills of the

interpreter; distortions related to the interpreter's lack of psychiatric knowledge; and distortions connected to the interpreter's self-imposed role and attitude toward either the patient or the clinician.

As stated previously, it would be optimal if there were enough bilingual psychiatric professionals so that non-English-speaking patients could be reliably evaluated. In the meantime, it is important, first, that clinicians be made aware of the interpreter-effect on the translation of psychopathology and, second, that interpreter training programs oriented toward the special needs of the mentally disabled be developed in mental health facilities in order to assure a minimum of adequate care to the non-English-speaking population.

ALTERNATIVE MODELS OF SERVICE DELIVERY FOR THE HISPANIC ELDERLY

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The following is an edited version of a paper presented to the National Hispanic Conference on Aging and Mental Health in Miami, Florida, March 1980.

Most of the ongoing discussion regarding the provision of appropriate services to the Spanish-speaking elderly has taken place within the context of the utilization and accessibility patterns of a wide range of traditional human services, including mental health services. There is now general agreement that this is a narrow perspective, for utilization rates and patterns do not address the actual needs of the elderly nor provide us with reasons for such patterns. Indeed, the limited data regarding service utilization patterns of the Hispanic elderly question the applicability and/or relevancy of the traditional service delivery models to meet the needs of the Spanish-speaking elderly in general.

From a much broader perspective, general disappointment with existing service models, patterns, policies, and procedures of service delivery is related to the dramatic increase in human service programs, including mental health programs, during the last 15 years, for the growth has taken place with little concern for the relationship among the different components of the service delivery models. The individual complexities of each program have led not only to administrative confusion and expense, but more significantly to confusion among the recipients of services.

This situation is complicated by the gross lack of information about the nature and extent of the variety of programs. More specifically, a wide range of complicated interrelationships has led to the failure of existing programs to treat the elderly in equal terms and very little evidence is available concerning the actual change in the level of health and mental health services and the housing and nutritional needs of the aging over this period of growth of services.

Evidence that the multiple service needs of the Hispanic elderly are not being met suggests that policy development and funding decisions by Federal agencies must be critically reexamined. Certainly, foremost in terms of importance, is the need for a national level, comprehensive strategy capable of responding to the multiple and unique needs of the Hispanic elderly. At the present time no overview of needs, programs, and policies has been developed, nor has there been any attempt to develop a coordinated research strategy.

The research that supposedly should guide decision making seems to have been developed in a piecemeal, uncoordinated fashion. Some believe that this approach has failed to stimulate the implementation of services capable of meeting the needs of the Hispanic elderly. They have taken the position that there must be a general plan developed which has to be far ranging, with a minimum scope of five to ten years, and within a meaningfully monitored process to ensure that the plan meets its objectives.

From the perspective of both scientific understanding and the delivery of appropriate service programs in meeting the needs of the Hispanic elderly, answers are sought to basic questions such as the following: How are the Hispanic elderly like and unlike the non-Hispanic elderly; and how are they like and unlike young Hispanics? What historical trends and development variables have led to their current situation in terms of both positive and negative adjustment? With these basic questions in mind it is imperative that we turn to the identification of a research portfolio capable of providing us with

THE HISPANIC EXPERIENCE OF CRIMINAL JUSTICE

The Hispanic Research Center announces the publication of its third monograph, The Hispanic Experience of Criminal Justice, by Peter L. Sissons, Associate Professor of Sociology, Fordham University. The monograph considers the question of whether or not the Hispanic offenders' collective experience is different from that of offenders of other origins while being processed through the criminal justice system. Data from a federal court are brought to bear upon this question. One of the findings reported in the monograph is that ethnicity interacts with the system in such a way that Hispanics receive harsher sentences and are more likely to be sent to prison than non-Hispanics.

Copies of the monograph may be ordered from Ms. Elizabeth Ospina, Administrator, Hispanic Research Center, Fordham University, Thebaud Hall, Bronx, New York 10458.

some answers that could help us in the development of appropriate services to this population group.

Alvin O. Korte states that "common to most of the studies now available there seems to be an attempt by the researchers to highlight the Hispanic elderly person's social situation by incorporating a complex mix of such diverse elements to include effects of organizational structures, cultural values, influence of the majority Anglo culture, membership in lower economic groups, encounters with discrimination and racism, as well as accounting for intraregional variations and influence by group specific local histories. To this end some researchers have linked theoretical perspectives with macro level perspectives such as modernization and/or colonization theories. For example, modernization theory serves as a framework from which to evaluate changing family values and family support systems. Micro level perspectives serve to highlight the personal impact upon the elderly in regard to these changes." ("Theoretical Perspectives in Mental Health and the Mexicano Elders." Chicano Aging and Mental Health, NIHM, 7/79. In print.)

The direction to follow is further obscured by the fact that we continue to debate and argue for a broader definition of mental health which would include social, economic, political and cultural perspectives. Dissatisfaction exists when traditional diagnostic and treatment procedures are used with patients from other cultures. For example, Dominguez-Ybarra and Garrison note that the trend is to reexamine the traditional treatment theories to see where they have prejudged minority group consumers of service, as well as majority consumers' needs from the lower socio-economic classes. One conclusion advanced by Dominguez-Ybarra and Garrison is that mental illness would have to be defined within the cultural context in which it is used. ("Towards Adequate Psychiatric Classification and Treatment of Mexican-American Patients," Psychiatric Annals **12**, December 1977, 86-91).

Some researchers in the field of aging have taken the position that rather than being concerned with psychiatric symptomatology the focus should be on self-esteem maintenance in the broader social-cultural matrix of aging within the Hispanic experience (Ibid, Korte, pp. 1-2).

Korte states that in developing a broader perspective of mental health, it is the absence of opportunity to meet basic and culturally determined needs that constitutes the gap between individual aspirations and availability of resources for their satisfaction. On this particular point, Valle, Claudewell, and Comers' definition applies. It states that:

> In order to understand mental health it must include both illness and health. Most importantly mental health should include people's feelings of worth in the context of the total cultural and societal system as well as within the identifiable groups to which they belong. (Ibid, Korte, pp.1-2).

The available research regarding the Hispanic elderly, most in the form of dissertations and other articles, addresses these issues. For example, Marta Sotomayor ("A Study of Chicano Grandparents in an Urban Barrio," Ph.D. dissertation, Univ. of Denver, 1973) details the function of remaining traditional roles for the Mexican-American elderly and what it means in terms of life satisfaction and/or finding meaning in the later years. Korte states that the concept of morale includes positive self-esteem, its maintenance and deterioration. He defines morale in terms of the broader perspectives of anomie, alienation and depression. His study attempts to differentiate the types of social interaction with immediate and extended family members, as well as with neighbors and communities in order to maintain high levels of morale. ("Social Interaction and Morale of Spanish-Speaking Elderly," Ph.D. dissertation, Univ. of Denver, 1978). Likewise, the study done by Francisco Nunez ("Variations in Fulfillment of Expectations of Social Interaction and Morale Among Aging Mexican-Americans and Anglos," typewritten) considers the unfulfilled expectation of social interaction as it impacts on the morale of the elderly.

The sense of powerlessness or inability to manage the social environment, a key factor in mental health, may be a function of historical antecedents seen as specific social contextual variables, as the work of Fernando Torres-Gil with the Chicano elderly illustrates. ("Political Behavior: A Study of Political Participation Among Older Mexican-Americans," Ph.D. dissertation, Brandeis Univ., 1976). He points out that for some elderly a lack of political efficacy is associated with being apathetic and inactive in political participation as well as having negative feelings about participation in age-related political issues. But these aged persons have had negative experiences with immigration and border officials which no doubt have affected their perception of involvement with the dominant society's institutions.

From a broader perspective that applies to the elderly, Armand Sanchez ("The Definers and the Defined," El Grito **3**, Summer 1971, 4-11) proposes that the Chicano situation is a problem precipitated by social, political and economic conditions. He adds that mental health without social health has little meaning. Mental health for the Hispanic consists in the full awareness of oneself as a distinct ontological entity with a philosophy that combines people, nature, and the universe. Finally, Sanchez asserts in his discussion of non-utilization of mental health services that the mental health agencies have failed to acknowledge and accept the varied Hispanic ways of life as a valid, viable, and dynamic expression of philosophy about human existence, ways of life which must form the framework for a definition of well-being.

The research agenda will have to specify and define the interrelationships that exist between the individual and the social environment, how that social environment impacts on the person's sense of well-being, how well-being is defined, and how mental health is defined.

Alternative Service Delivery Models

Among Hispanics in this country, discussion and experimentation with alternative service delivery models is not new. In fact we can state that alternative lifestyles and modes of expression lie at the heart of our struggle and are a logical consequence of the opposition to the melting pot theory that discredits and obliterates differences. Therefore, discussion of natural helping systems as alternatives to existing mental health service delivery models is not only crucial, but most timely as we discuss policy development, define mental health from a broader perspective, and identify a research agenda to guide program development.

The term "natural systems" has often been used interchangeably with informal and/or self-help systems. These systems are characterized by known and accepted patterns and interrelationships for the purpose of mutual and reciprocal help. They can be based on kinship, friendship, or blood ties which operate on an ongoing basis or which are reactivated as needed. These relationship patterns can provide concrete help such as food, clothing and money, or other types of services such as emotional support within group norms and/or expectations.

For purposes of this paper we identify three resource helping networks, that is, the barrios, the extended family, and the compadrazgo networks. For example, a Hispanic barrio can include various types of mutual-help styles that illustrate elements of differentness from the general cultural helping patterns. Such neighborhoods traditionally have provided a form of community life for the Spanish-

speaking resident and continue to perform such a function for the constantly arriving new immigrants. As waves of immigrants have continued to arrive that neighborhood is the place where they first settle since the elements of a common language, similar values, customs, expectations and so forth are found there.

Barrios have been and continue to be cultural and nurturing communities that have allowed for the development of coping mechanisms and skills that utilize human resources and allow for a greater enhancement of the available human potential. The study of self-help networks in the barrio can illustrate the various stages through which institutions are formed, human motives expressed, and a specific social order molded. They are not only a means through which crystallization of needs and practices rooted in sentiment, customs, language and heritage take place, but are also areas where people come together to find some amount of security. Barrios with their potential for emphasis on community and family networks illustrate the ways in which a cultural group gives expression to its heritage in a foreign and hostile setting.

One can contend that in the barrios mutual help is characteristic, that it has always been immediate, concrete, to the root of the matter, not susceptible to administration by third parties, and always creating and reinforcing a sense of mutual obligation over time. For example, some of the most obvious and satisfying efforts of self-help in the barrios have been the establishment and maintenance of cooperative child care arrangements in which the grandparents have always had an important function.

If one were to measure the parameters of extended family patterns, the self-perception of the elderly, the role they play, and the direction they offer to other family members, one would find important and significant indicators of the self-help process. Recent studies indicate that elderly Chicanos have a strong family orientation and look to the family for close emotional-social relationships and that they place primary value in times of crisis in the extended family instead of non-relatives. One can maintain that there is a traditional cultural basis for this orientation.

F.M. Carp determined in her San Antonio, Texas, study titled "Housing and Minority Group Elderly" (Gerontologist **9** (1), 20-24) that Chicano elderly are strongly attached to the extended family through a demonstrated high preference for familial affiliation. In a USC study in Los Angeles it was found that Chicanos age 45 and over had a stronger familistic orientation than either Anglos or Blacks. (Carp, op. cit., p. 10). Carp also found that Chicano elderly were most likely to be living in the same neighborhood as some of their children with considerable and frequent interaction among them and this was true whether they lived independently, with a spouse, or alone. Additional support for this observation is provided by the recent large-scale study of Chicanos (over 600 families in Southern California communities) (Keepe, S.E., Padilla, A.M. and Carlos, M. "The Mexican-American Extended Family as an Emotional Support System," Human Organizations, 1979, **38** (2), 144-152) which found the same living arrangements to be common. Such living patterns point to a modified extended family structure with the elderly maintaining independence combined with close regular contact with children and grandchildren, and, while there are some distinct structural changes, the fundamental familial functions are maintained.

Living arrangements of the elderly can include residence with children and/or grandchildren. Eighty percent of Sotomayor's Denver sample had children in the home, and in the USC study 65 percent of the elderly (compared to only 25 percent of the Anglo elderly) had youngsters living with them. But perhaps the strongest evidence comes from Korte's New Mexico study. Korte attempted to divide both his rural examples into two groups, those who prefer extended and those who prefer nuclear family types. However, this approach failed because virtually all respondents had a strong preference for close contact and a mutual support pattern with their extended families. He points out that in both rural and urban areas the elderly have retained traditional family values as well as high expectation for mutual aid, affection and propinquity with their extended families.

One manifestation of the familial orientation is the desire of elderly to live near their children. In Denver, Sotomayor reports that the majority of elderly respondents had moved from rural areas to Denver specifically to be closer to their children. Moreover, all of these respondents indicated that they would turn to their relatives for help and all but one preferred social and recreational activities with relatives rather than friends. This finding was supported in the San Diego and USC studies with an entirely different elderly population group.

While the elderly respondents in the above-mentioned studies indicated their preference to having separate living arrangements, they chose housing close to their children. Emotional closeness, types of relationships and arrangements were also evident and this included situations where a grandmother finds considerable satisfaction in having the grandchildren stay with her. The depth and strength of their involvement was demonstrated in grandparents' participation in the day

problems of living with their children and grandchildren. Several studies indicate the concern of the elderly for the decline in the morals of their children and grandchildren and attribute the decline to the impact of modernization.

It appears then that, at least for the Chicano elderly, their particular concern is kinship alliances for mutual help, the frequency of interaction, and their role in the maintenance of cultural systems. The emphasis is placed on real people doing things together rather than on the formal ways of the social structure.

The compadrazgo pattern (a voluntary social network which may include blood and non-blood related members and which is formalized through religious ritual) appears as a typical natural helping network among the Hispanic populations. Such a network increases with each religious event such as baptism, confirmation, 15th birthday celebration for girls, marriage, etc. For example, at least three pairs of padrinos (godfathers and godmothers) could be acquired at a marriage ceremony and more with the baptism of a child. This network is further extended by intra- and inter-relationships of compadres, padrinos and ahijados, parents and compadres of compadres. The cycle is socially repeated with each additional birth. This cultural networking still exists and variations of it are probably found among the various Hispanic groups in this country. The most significant characteristic of this relationship is the reciprocal responsibility to other compadre networks and the children involved in such networks.

Many Hispanic traditional families still can be characterized by the specific delineation of task and function that deals with conjugal conflict or tensions and problems with children through closer extended kinship networks. Emotional and economic needs are still shared among the extended kin to include the extensive compradazgo network. Responsibility and centralized control that one would expect to be delegated to specific members of the family, primarily the father, are in reality shared among the extended networks to include blood kin and compadres.

Within this complex of extended interrelationships and mutual aid responsibilities there is probably no more clearly delineated authoritative role than that of the grandparent. The aged parent has always had a role of considerable significance with the Hispanic traditional family. Not only do the grandparents aid in time of crisis and ensure that their children meet familial obligations, but, in turn, expect reciprocal relationships of the grown sons and daughters, not only for economic support, but for emotional needs as well.

While all of us agree that voluntary associations cannot meet the needs of all

the elderly, we need to study natural networks, to determine their composition and their utility in serving the unique needs of the Hispanic elderly and as a survival service delivery system. As a cultural coping mechanism, natural networks would seem to be most useful in supporting the elderly person in his/her home and neighborhood. In this respect Ramon Valle and Lydia Mendoza (The Elder Latino, San Diego: Companile Press, 1978) studied patterns of respondents in utilizing mental health services and respondents' cultural attitudes toward helping and being helped. While additional research will probably uncover the density, extent, and limitation of these networks, at present the Valle-Mendoza study identifies and supports the value and viable functions of available networks. Valle's earlier works in San Antonio and Houston illustrate the possible universality of mutual help networks in urban barrios.

Natural networks appear to fall into a category that can be termed as a coping structure of barrio institutions and such networks may be one of many barrio institutions which we need to support. Valle points out that three distinct levels of natural networks can be encountered among the Chicano elderly. These three types of networks not only remain active within the current United States Chicano community, but their social historical presence can be traced as a primary group progresses through both the Olmec-Toltec and Ibero Hispanic heritage of this population group. (Valle, Ramon and Martinez, Charles. "Natural Networks of Latinos of Mexican Heritage: Implications of Mental Health." Chicano Aging and Mental Health, NIMH. In print.)

In this context natural networks have to be understood as culturally imbedded phenomena and emerging gerontological theory makes the concept of cultural imbeddedness central to understanding the elderly. Several gerontologists such as Kurt Back, V. Bengston, and Neil Cutler stress the critical importance of generational imprinting (which is cumulative and cultural) in understanding the behavior of the elderly. The uses and value of natural networking tends likewise to be verified by the literature on natural networks in general.

In conclusion, by virtue of their availability, natural networks represent a potentially powerful helping resource for the mental health care giving systems. The approach then is for the mental health system to broaden its perspectives of mental health and illness regarding Hispanics to include natural networks through all phases of the mental health intervention for the purpose of utilizing and meeting their needs in culturally relevant ways. These networks represent the "significant others" of the Hispanic elderly experience that can work to facilitate mental health service delivery. These natural networks can also serve as examples of the appropriate mode of communication and service delivery that can provide direction to the Hispanic elderly in need.

The introduction of such an approach would give the mental health provider a number of cultural approaches and mechanisms that can complement traditional interventions and provide a link to the Hispanic elders' historical past as it comes to bear on current problems and concerns. The ability to appropriately identify and include culturally imbedded values and structures pertinent to the Hispanic elderly consumer of services can present an opportunity to mobilize various types of in-place supportive services and add to our mental health related interventions. This can also increase the overall capability for ongoing analysis of the individual Hispanic elder's behavior vis-a-vis his or her appropriate psychological context.

We are not proposing that the natural networks take the place of the formal caregivers in the mental health arena. On the contrary, these endogenous systems can operate parallel to and can be supportive of existing services. Natural network interventions and formal mental health intervention should be seen as a joint venture. Both the formal care giving system and the natural network operating independently, working consciously together, utilizing the inherent psychological and emotional capabilities of each, are the most effective approaches. This suggests that professional capabilities be improved through incorporation of the natural helping networks into the formal mental health care giving strategies.

UNDOCUMENTED MIGRATION: ISSUES AND TRENDS

By Elizabeth Collado, Staff Member, Hispanic Research Center

In this year of the Census and in our continuing effort to disseminate information about, and stimulate interest in, issues of Hispanic concern, the Hispanic Research Center hosted a lecture entitled "Undocumented Migration: Issues and Trends." The presentation was made by Dr. Charles Keely whose books and numerous articles dealing with U.S. immigration policies and the controversial issue of illegal aliens have earned him a reputation as a nationally renowned expert on this question.

Dr. Keely's lecture provided a comprehensive overview of undocumented migration with a particular focus on the history of U.S. reaction to the situation as manifested through its policy formulation. His remarks touched upon four substantive areas: (1) the causal factors behind undocumented migration as an issue, (2) the various areas of controversy and the reasons for their having gained prominence over other matters, (3) proposals for the management or solution of the problem, and (4) the peripheral issues which have evolved around undocumented migrants.

A Brief History of U.S. Immigration Policy

Prior to 1917, undocumented entry into the country did not pose a problem. In that year visa requirements and the formation of border patrols created obstacles to be surmounted by those wishing to gain entrance into the United States.

By the mid-1960's immigration restrictions became more intensified. In 1964 the United States unilaterally terminated the bracero program which had been in effect since 1942 as the result of bilateral agreements between this country and Mexico. The bracero program had permitted unrestricted entry of workers to serve as transient labor, first, in copper mining and the construction of railroads, and, later, in agriculture. The nullification of these agreements was largely due to protests launched by pressure groups in the U.S. who were outraged by the unconscionable conditions to which this transient labor force was subject and by opposition from farm union organizers. Labor leaders believed that the availability of a cheap labor pool deterred union organizing and recruitment and undercut wage rates for American agricultural

workers.

In 1965 the Immigration Reform Act was prompted by various groups who wanted to abolish quotas on immigratio... Their aim was to end the national origins quota system which affected mainly immigrants from Europe. Envisioning a sudden "danger" to the integrity of the U.S. racial/ethnic mix should such a relaxation of quotas take place, a number of Southern legislators inserted a provision into the new law to limit immigration from the Western Hemisphere to 120,000 annually. In force as of 1968, the law exempted only the spouses and children of U.S. citizens from the 120,000 figure.

To further impede migration, a Labor Clearance stipulation was added by U.S. immigration officers. Henceforth, anyone from the Western Hemisphere seeking to enter the country had to prove that a job offer had been extended for which there were no Americans available, and accept the prevailing minimum wage rate and conditions for the particular job. Only after these conditions had been met would permission to legally enter the U.S. be granted. Taking into consideration the barring mechanisms which were being imposed, Dr. Keely stated that it is within the context of restriction that illegal migration movements are spurred on a wide scale.

Why Has Undocumented Migration Achieved Prominence as an Issue?

The 1970's heralded the decade in which the issue of illegal aliens became salient in the public eye. Immigration officers first attracted public attention to the situation when they began to arrest persons with deportable alien status.

In 1973 the Nixon Administration took advantage of the situation to increase the Immigration Department's budget and manpower force. The economic climate of the time was critical—a recession prevailed and the Arab oil embargo was further aggravating the crunch. Leonard Chapman, appointed by Nixon to head the Immigration and Naturalization Service (INS), felt that the time was ripe to institute a public education campaign. He fomented public opinion against undocumented workers with promises of alleviating unemployment and curtailing taxes if only the "flood" of illegal migration could be stemmed.

Just how extensive this army of foreigners actually was required several studies to determine accurately. Chapman's original estimate placed the figure as high as 12 million. A dumbfounded Congress requested a more precise appraisal, and the first of three studies to arrive at a tangible figure was initiated.

The Lesco Study, conducted in 1975, relied on the estimates of six so-called experts who were never required to account for their source of information. They arrived at a mean figure of 8.2 million, an estimate considered ludicrous by the Bureau of the Census and which subsequently resulted in the invalidation of the study. The following year, a request issued to Immigration's regional directors produced a figure of 6 million. This estimate was made within 3 days of the original petition and was based on a "non-scientific statistical estimate."

The third study, undertaken by the Inner City Fund, availed itself of the figures from the already invalidated Lesco Study and made the stirring announcement that undocumented migrants were costing the public treasury $16 billion annually. Obviously, Chapman's program did not accurately identify the true numbers of undocumented migrants, but it triumphed at arousing public indignation and concern.

The questions raised by Chapman's campaign centered upon three major issues: (1) How many illegal migrants were in fact living in the U.S.? (2) What were the economic repercussions caused by their presence? (3) Exactly how much were these migrants costing the public treasury?

The numbers question was resolved by several record-matching studies which linked inflated death rates among young adult males caused by violence (the category of highest death rates) to the existence of persons for which no other records could be located. This analysis placed the illegal population figure in the area between 3 and 5 million. Of these, the proportion of Mexicans was found to be from 50 to 60 percent. This demonstrated that the problem was not purely Mexican but also involved other nationalities: Dominicans, Jamaicans, Peruvians, Ecuadorians, Colombians, Guatemalans along with Israelis, Greeks, Italians, Asians and Nigerians.

Regarding the economic impact created by the undocumented, Dr. Keely made several observations. Illegal migrants work long, hard, and cheaply. They comprise a docile and politically impotent labor pool which is extremely profitable to the packing and other agri-business interests in the West and Southwest. In the Northeast, undocumented migrants, especially women from the Caribbean area, are located in the service sector, engaged largely in menial hospital jobs. Their elimination would very likely produce a marked reduction in hospital services.

Illegals also constitute the mainstay of New York City's garment industry — the sweatshops so notorious for their exploitation of cheap labor. Were this labor force to be removed, the garment industry could very well collapse, with inevitable repercussions for those U.S. professionals, merchants and businessmen whose livelihood is attached to the viability of the clothing industry.

The displacement argument, according to Dr. Keely, is overstated and perhaps falsely presented. It is highly unlikely, he affirmed, that an unemployed American would consider a job in New York City's sweatshops acceptable or that he/she would be willing to replace the scorned "wetback" in the onion fields of the Southwest.

The third contention – that illegal migrants drain the public treasury of astronomical amounts of dollars annually – Dr. Keely countered by pointing out that the undocumented do contribute to public coffers through sales taxes, wage taxes, and rent payments, a portion of which goes toward the meeting of property taxes. The argument may be extended yet further by stating that the undocumented population may very well compose the group which least utilizes public institutions such as hospitals and schools due to the fear of detection and betrayal which permeates their daily existence. Despite the evident flaws in the arguments presented by those favoring immigration restrictions, the issue is still viewed as one definitely requiring solution. The Employment Sanctions Plan (ESP) has been proposed to "nip the problem in the bud" by denying migrants access to the labor force and by enforcing penalties against employers who violate the law by employing illegals. The crux of this plan would necessitate the creation of an identity system modeled after the Social Security card and make such cards difficult to obtain. The measure would also require periodic and selective inspection of industries and workplaces where illegal migrants are traditionally located. Although this idea has been promoted as no less threatening than the Social Security System, it is arguable that the more foolproof a system seeks to be, the more dangerous it becomes from a civil libertarian perspective.

A proposal with more possibilities for success is encompassed within the recommendations laid down by the Commission of Immigration and Refugee Problems. The basic features of this plan are: (1) To increase the annual quota of immigrants to a total of 1 million annually. This number would be divided among refugees (about 200,000), families of U.S. citizens (about 500,000), and supplementary labor needed to meet shortages. These persons would be admitted with all the rights accorded U.S. citizens. (2) No specification would be made regarding country of origin. Thus, the U.S. would revive its tradition as a haven for refugees from all lands.

The enactment of this proposal would

serve to eliminate the perceived problem of undocumented migration. Presently, only 600,000 immigrants are entering the country yearly, including Indo-Chinese refugees. Furthermore, immigration would be balanced by emigration or the expatriation rate. Contrary to popular belief, not all foreigners choose to settle in the U.S. and many native-born Americans elect to leave the country as well. This movement would ultimately maintain the net number of immigrants below the 1 million mark.

Pending the adoption of a viable and more humane solution to eliminate undocumented migration as a problem, the impact created by ongoing movements has resulted in two court actions of special significance. One suit was filed by the Federation of Americans for Immigration Reform joined by 26 members of the House and Senate. The case, argued in a district court of Washington, D.C., sought to prevent the counting of illegals for purposes of apportionment. The charge was that including the undocumented in the 1980 Census was unconstitutional. The court voted to deny the suit on the basis that the undocumented have no standing, thereby dismissing the question of constitutionality as irrelevant to the case. In addition, the court ordered that all persons in the nation be counted.

A second case is still being heard in the State of Texas. The Texas School Case involves a suit which asks that the court strike down the ruling passed by that state's legislature which forbids the children of those unable to prove legal residence from attending the public schools. This case is particularly interesting because, in addition to reflecting resentment and antipathy towards the undocumented, it is also indicative of regional differences in the value placed on education. As Dr. Keely emphasized, New York City requests no proof of citizenship when a child is enrolled in school.

Dr. Keely concluded that the problem of undocumented migration has been one created by U.S. policy makers, and especially aggravated by the 1965 Immigration Reform Act. Such policies have surfaced from an ideology, now dominant in the society, which places limits on growth. The solution favored by Keely, and by others who endorse revitalization of past U.S. "open door" traditions, is increased economic growth which will adequately accommodate present citizens and all who wish to enter as well. Present positions on immigration, nevertheless, appear pessimistic about future economic expansion. Dr. Keely summed up the seminar by stating that ultimate resolution of the problem of undocumented migration rests with our answer to the following question: Are we, as a nation, hopeful or fearful about our future?

HISPANIC RESEARCH CENTER RESEARCH BULLETIN

The HRC is directed by Dr. Lloyd H. Rogler, Albert Schweitzer Professor in Humanities at Fordham University.

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